Adopted November 21, 1997 by the Managed Health Care Improvement Task Force

STANDARDIZING HEALTH INSURANCE CONTRACTS
FINDINGS AND RECOMMENDATIONS

I. HEALTH INSURANCE CONTRACTS

Health insurance contracts are extremely complex and difficult to interpret, even by experts. This complexity is inherent in the nature of the subject and not necessarily the result of any deliberate action on the part of health plans[1] or the employers whose health plan contract decisions may add to the complexity. The complexity of health plan contracts makes it very difficult for an individual or small group to be a competent purchaser of health insurance.

Complexity offers insurers opportunities to exercise strategies that promote their economic advantage. While all health plans may not employ these strategies or may not employ them intentionally, but rather to accommodate consumer or employer demand, these strategies can put upward pressure on the price of health care coverage. Strategies include (1) product differentiation that makes comparisons difficult, decreases the incentive for health plans to offer lower prices, and raises switching costs by making it more "expensive," in terms of time for example, for a consumer to switch plans to save money; (2) market segmentation that may reduce competition by dividing customers into distinct groups, with each insurer marketing products to attract different segments from those chosen by competitors; (3) risk selection by designing products that are unattractive to high risk persons; and (4) coverage exclusions, not readily apparent in health plan contracts or read by most individuals.

II. STANDARDIZATION TO SIMPLIFY, COMPARE, AND REDUCE COSTS

To assist consumers, major purchasers have standardized health plan contracts. In order to offer both HMOs and PPOs, purchasers must vary the cost-sharing requirements of contracts. However, a standardization policy can seek to make contracts as similar as possible. Standardization will increase understanding, reduce administrative costs, and facilitate consumer comparison of plans.

Implementation of standardization has proven difficult at the level of detail. Issues regarding definitions and coverage exclusions will continue to challenge attempts to standardize until greater clinical agreement exists. Despite its challenges, standardization has worked successfully for major purchasers in California. However, while large employers and employer coalitions have the resources to assist their members adequately without assistance from regulators, small groups and individuals do not. Recently, Congress passed a law dictating that only approved reference packages could be sold in the "Medi-Gap" market for supplemental Medicare insurance. Indications so far are that this market is now working much better for consumers.

Standardization need only apply *within* sponsored groups, i.e., the set of people choosing among a set of plans; it does not need to apply among them, i.e., across employers purchasing separately. The principle of standardization does not imply that small business must be offered the same packages as large employers. Standardization need not and should not be complete or mandatory, as this would reduce choice and stifle innovation.

A. Concerns Regarding Standardization

Standardization has been criticized as denying people choice of product features. Certainly, there is need for choice: consumers want it, and it provides a source of constant innovation. Options and innovation often benefit consumers, and standardization should not preclude them. However, because of the potential

[1] In this paper, the term "health plans" refers to any health insurance arrangement or health benefits financial intermediary.

for risk selection (for example, the only consumers who will want coverage for durable medical equipment are those who know they need it), some standardization is desirable. Whole groups must make a decision as to whether or not they want a particular type of coverage, and if they do, they need to apply this standard uniformly to all plans serving their members.

Controlled departures from complete standardization are possible and desirable, for example, but must be balanced against the benefits of standardization, with special care not to select risks and segment markets.

B. Standardization Options

There is a continuum of pro-standardization policies that the state could adopt. From the most prescriptive to the least, they include, but are not limited to:

- A uniform, national contract, as is the case of Medicare.
- A "Medi-Gap" solution. This would involve a set of standard coverage options and a requirement that, at least in certain markets (e.g., small group market); insurers offer only those products.
- A set of "endorsed, standard reference packages," designed and updated periodically in consultation with the Major Risk Medical Insurance Board (MRMIB), small business associations, small group purchasing organizations, consumer organizations, health plans, and providers, and reviewed and approved by the state entity(ies) for regulation of managed care.[2] Health plans could be required upon request of employers and consumers, to provide a clear and concise comparison between any plan they offer in the small group or individual market and one of the reference contracts.

III. RECOMMENDATIONS

Non-standard health plan contracts add to financial and other costs associated with switching plans, help to segment markets, and decrease the incentive for health plans to offer lower prices, thus raising prices to purchasers and consumers. Market efficiency can be enhanced by standardization within large groups and by making endorsed standard reference contracts available for comparison in the small group and individual market.

1. The state entity(ies) for regulation of managed care should be directed to adopt a pro-active policy toward the development of standard reference health plan contracts that can be used by buyers and sellers by reference, that health plans can offer on a fast track basis through the regulatory process.

2. (a) The state entity(ies) for regulation of managed care should be directed to develop a set of five (5) standard reference health plan contracts in each of the HMO, POS, PPO, and indemnity product lines, from minimal to comprehensive, that can be used by buyers and sellers in the small group and individual markets along with explanatory materials to help buyers understand their choices.

   (b) This should be done in consultation with the Major Risk Medical Insurance Board, and stakeholders.[3]

[2] Throughout this document, the state entity(ies) for regulation of managed care refers to the Department of Corporations, the Department of Insurance, or their successor.

[3] The intention of the Task Force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.

(c) On a biennial basis, the state entity(ies) for regulation of managed care should re-examine standard contracts and adopt modifications as appropriate.

(d) Small business would not be required to limit its choices to these standard packages, but in addition would be able to select any other contract health plans offered. In effect, approval by the state entity(ies) for regulation of managed care for the standard contracts would be "fast-tracked."

(e) Health plans should be required to publish and provide upon request by employers or consumers, a clear and concise comparison between any product they offer in the small group or individual market and one of the reference contracts.

3. (a) The state entity(ies) for regulation of managed care should be authorized and directed to convene a working group to develop a standard outline and definitions of terminology for evidence of coverage (EOC) and other documents to facilitate consumer comparison and understanding.

(b) The working group should include the major stakeholders and should build on previous accomplishments by organizations such as the California Public Employees Retirement System, Pacific Business Group on Health, and the Health Insurance Plan of California. The regulatory entity should convene the working group on a biennial basis to consider modifications.

(c) When consensus has been achieved, the regulatory entity should promulgate proposed rules for consideration and adoption, subject to notice and comment proceedings.